The Hampden Hippocrat

MAY 1970

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THE HAMPDEN HIPPOCRAT
·1942·

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The Massachusetts
Medical Society

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OF MYTHS AND SACRED COWS

There is an ever growing rumble throughout our nation that the price of American medicine today is indefensively disproportionate to its quality, quantity, and availability; moreover, the cure-all is a national health insurance plan providing comprehensive health care to all the people at all times. The fact that costs of health care of late have been spiraling is not unique to the United States. It has recently been pointed out, for example, that total expenditures for hospitals in the U.S. have risen 131% in an eleven year period, while in England they were rising 128% and in Sweden, 223%. Data from other developed countries of the world reveal the same conditions. Causes of spiraling costs have been many and with varying degrees of influence, namely, health manpower shortages, the rapidly rising value scale for health, greater expectations and demands for more and higher quality care, demand for immediate utilization of new and improved technology, ready availability of optimal health care equally to all, etc. Realizing that constituents must be satisfied and pleased, those in power and desirous of remaining so, turn to scapegoating and proposing changes in the systems of financing and delivery of health care services.

PRIVATE VS. GOVERNMENTAL INSURANCE

In a talk given at the New England Hospital Assembly in Boston during the latter part of March of this year, United Autoworkers President, Walter P. Reuther gave an address wherein his following statements set the keystone for the new health care system.

"The concept of national health insurance is an idea whose time has come in this country."

"After 20 years, we have got to be honest. We must recognize the simple basic truth that private insurance has failed because it lacks the capability of providing universal coverage and any mechanism for control of costs or quality."

"Private insurance is incapable of marshalling the uniquely creative, financial leverage to bring about a workable delivery system."

"Out of national health insurance we can bring to bear the massive leverage to shape the dynamic change that is necessary to restructure the delivery system — the basic source of our problem."

THE MAGICAL RECIPE

What is this new delivery system which purportedly will be the salvation of mankind's health? Simply stated it is group practice of medicine, preferably prepaid and preferably hospital based. A "classic" definition runs: "Group medical practice involves the cooperative organization of five or more full-time physicians representing at least 3 specialized fields of medicine, using common facilities and staff, and sharing responsibility for the provision of comprehensive medical care to a continuing clientele . . . with income from medical practice pooled and redistributed according to some prearranged plan." Add to this the prepaid feature which includes compensation to the physician from an enrolled consumer population on the basis of a per capita, fee-for-time, salary, or combination thereof and center the group in a hospital.

Clustering doctors into hospital-based group practice will unquestionably boost quality and improve efficiency. Private solo practioners are reportedly rendering poor quality of care; whereas, in a group the individual's work would

be subject to the scrutiny of his peers. Moreover, there would be even stronger scrutiny when such a group is affiliated with a hospital. Physicians' privileges would be restricted stringently to procedures which training and demonstrated ability allowed. This would not only preclude poor and even disastrous results but also unnecessary surgical utilization. More time would be available for better patient-physician relationships by taking advantage of computers and other time-saving technologies thereby making medicine less mechanical and more personal. Free choice of physician is of no importance because the patient really can't judge medical competence. Insofar as remuneration is concerned, free-for-service is piecework and can "seduce a doctor into placing cash before care"; moreover, it "encourages unnecessary procedures and, through its open-endedness, leads to inordinate rises in fees." A salary based on qualifications, abilities, experience, and the nature of his specialty as determined by his co-working peers would be the physician's reward, (also depending on the amount of cash in the pool's till) to say nothing of fringe benefits that go with group practice and the satisfaction of having given nobly to his brothers.

So go the praises for this relatively untried, new delivery system which would be launched by the "great white father" and his apostles.

THE OTHER SIDE OF THE COIN

Before buying the new delivery system under fiscal sponsorship of a national health insurance plan, let us draw on the experiences of some of the other such national programs. It seems that "when a service becomes a 'free' right, the system is not so much used as demanded and abused." Moreover, human nature tends to judge quality of a service by its cost. After all, you only get what you pay for. If it costs little to nothing, then that's all it's worth! With no fee there is lack of setting priorities in spending money and lack of responsible judgment on the part of the patient.

It must be remembered that whatever the plan or system, the demand for medical care is unlimited and the supply is limited. As prepaid benefits grow, demand will grow, and manpower resources will be even heavier taxed than at present. Who is to place limitations on demand and on the basis of what criteria?

In England something like two million rightful wards of the Crown's health scheme have bought private insurance to gain free choice of (and a shorter waiting line for) physicians, better bed accommodations, and other conveniences.

It's very interesting to note that escalating costs are the prime reasons given for most national health insurance proposals; and yet, the proponents never mention how much more such a plan will yield and cost over what we already have. Maybe our current delivery system (or non-system) of health care may have its shortcomings, but can we improve upon it by pouring more billions of dollars into a new system without knowing that the so-called proper approach is a mistake?

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HIGHLIGHTS OF THE APRIL EXECUTIVE COMMITTEE MEETING

The April meeting of the Executive Committee was held on Tuesday, the 21st, in the Conference Room of the HDMS.

Present were Drs. Turner, Stoler, Anton, Barnes, Cummings, Moore, Kelly, Boivin and Mrs. Purdy.

In the absence of Dr. Mozden, Dr. Turner presided.

The Executive Committee voted to dispense with the reading of the March 17, 1970, meeting.

CORRESPONDENCE

Informational letters from Wesson Women's Hospial and Wesson Memorial Hospital were read concerning full-time medical men on the staff and the corporate practice of medicine.

A letter from Dr. Bernstein calling attention to an advertisement in the *Springfield Herald* by a Mr. Claude LaPlante claiming he can help allergies, asthma, etc., with hypnotism was read. The Committee decided to refer this to the MMS for questions of legality.

The minutes of the meeting held on March 20, 1970, in the HDMS office by the Conn. Valley Health Planning Council regarding the establishment of a Multi-Service Health Center in Springfield by the State were read and discussed. It was decided to discuss this health center proposal at the May meeting when Dr. Mozden can be present to give the Committee some additional information.

Two letters were read from Dr. Gephart. One was concerning the resolution introduced by HDMS relative to amending the General Laws of 1941 pertaining to Blue Shield. Dr. Ayres, Executive Councilor, who will attend the MMS Executive Committee meeting on April 22, will present more information at the next meeting of the Committee.

The second letter concerned the Massachusetts Hospital Association Bulletin #12 about the special Blue Cross agreement. This has been forwarded to Mr. William Robinson, Executive Secretary of the MHA by Dr. Gephart, but no answers have been received as yet. A letter will be sent to Dr. Gephart asking for answers from Mr. Robinson.

COMMITTEE REPORTS

The Member's Insurance Committee met on April 14th. A brief report was given. More information from Dr. Tillman will be sent to the Committee later

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on an updated insurance program for members.

Dr. Moore, Treasurer, presented the financial report for 1969-1970 and the Budget for 1970-1971. He recommended that the dues stay at $50 for the ensuing year indicating that no new equipment was anticipated at this time. The Committee voted unanimously to accept the report and the budget.

OLD BUSINESS

The names of the members of the ad hoc committee on Peer Review as appointed by Dr. Mozden were read. Several suggestions were made by the members to include other specialties such as pathology, radiology, dermatology as well as someone from Westfield and possibly an insurance physician. Dr. Turner will consult with Dr. Mozden in regard thereto.

NEW BUSINESS

Two resolutions were presented by the Committee on Hospial and Physicians Relationships. The first one was tabled, and the second was reworded and is to be presented at the Annual Meeting.

The 90 day billing is being reactivated by the Mass. Dept. of Public Welfare and new forms are now available from the Department.

Mr. Bernard Greenberg, Welfare Chairman of the Springfield Druggist Association, attended the meeting for a short time to discuss the fixed profit on each prescription by edict of the Mass. Welfare Department. He asked that the HDMS support the druggist's protests against this regulation. The Committee asked that he put his requests in writing for the Executive Committee to consider.

The meeting was adjourned at 9:20 P.M.

The Grievance Committee convened and heard two cases.

The meeting was adjourned at 9:40 P.M.

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HDMS ANNUAL MEETING HIGHLIGHTS

The annual meeting of the HDMS was held on April 28th at the Shaker Farms Country Club in Westfield with President Mozden calling the meeting to order at 6:25 P.M.

Attendance: 114, including 12 without reservations; 128 made reservations with 26 failing to attend and cancel their reservations.

The minutes of the regularly scheduled meeting of February 3, 1970, were accepted as read with a few minor corrections.

The members present then observed a moment of silence in respect for the 10 members of the Society who had passed away during the year: Joseph Angelica, Springfield; Edward P. Bagg, Jr., Holyoke; William J. Dillon, Springfield; Albert W. Ghoreyeb, Springfield; Edwin M. Mahoney, Holyoke; Stephen A. Mahoney, Holyoke; Richard V. Paul, Springfield; Norman A. Pokorny, Springfield; Amber A. Starbuck, Middlefield; and Stanley S. Stusick, Springfield.

Thereupon, President Mozden called attention to the annual committee reports without recommendations as published in the April issue of the *Hippocrat;* these were accepted as published.

Dr. William Beachman, representative to the MMS Committee on Tax-Supported Medical Care announced that supplies of the new Medicaid billing forms may be exhausted; hence, he advised that physicians use their own billing forms with a notation at the bottom that approved billing forms were not available. He also announced that the 90 day billing rule for Medicaid was in effect but that the timing begins when the physician provider finds out that his respective patient is on Medicaid. Moreover, he warned that physicians must send a copy of the bill to the Medicaid patient until such time as this statute requirement is rescinded.

The Treasurer, Dr. Paul T. Moore, reported that receipts for the fiscal year 1969-1970 were $22,651.83 and disbursements $22,568.07 with a balance of $4,326.63 on hand as of April 1, 1970.

A budget of $23,500 for the coming fiscal year has been approved by the Executive Committee with an anticipated income of $21,050 from dues at $50 per member. In the light of the aforesaid, it was recommended that the dues remain at $50 per member for the coming year. This report as well as the dues recommendation was approved along with the report of the Auditing Committee, which found all the accounts in order.

There being no old or new business to discuss, the meeting recessed at 6:50 P.M. for the collation.

At 8:30 P.M. the meeting was reconvened with a talking slide presentation by Mr. Edward Donelan, AMA's regional representative, of the AMPAC workshop recently held in Washington, D.C.

President Mozden then reported on the questionnaire survey of the membership which had been carried out earlier in the year (see page 21).

Following this, Dr. Olive A. Cooper was honored with a presentation of a 50 year membership certificate.

The report of the Nominating Committee was presented by Dr. Carlo Q. Montori; this was unanimously accepted as presented (see page 11).

Retiring President Mozden expressed his gratitude to all who assisted him during his tenure of office and thereupon introduced the new President, Dr. John W. Turner. After rendering a brief inaugural address, President Turner announced his appointments to the various committees of the Society for the coming year (see page 12).

There being no further business, the meeting was adjourned at 9:15 P.M.

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PRESIDENT'S PAGE

INAUGURAL ADDRESS

Our Society has survived 130 years. Two bonds join us. One is the M.D. degree. The other is our mutual concern for the health of patients in the Hampden District: Ware and Westfield, Holyoke and Chicopee, Palmer and Springfield, and other towns.

Never have we as physicians had so much to offer our patients in effectiveness of medical and surgical procedures or in numbers of qualified men in the various branches of medicine.

At a time in our nation's history when the waves of revolution are washing against the foundations of our institutions, of religion, higher education, and of American socio-economic traditions generally, we cannot expect that medicine is to be exempt.

Medicine has a tradition in the Hampden District as elsewhere, to serve the elderly, the crippled, and the indigent. This tradition antedated Medicare and Medicaid by generations. Now we are facing new patterns for serving all who need medical care. Despite predatory pronouncements of politicians and journalists against the medical profession, let us sharpen our focus on all patients with real needs. Big government has unwittingly promised twice as much as even its own actuarial predictions indicated. Now hospitals and physicians are asked to subsidize political overpromise. As a profession, we are further suspect because our fees have only recently surpassed amounts spent annually in the U.S.A. for tobacco.

In this Society let us work together and reaffirm our interest for continuation of constructive enterprises as in the pattern of our recent past: polio immunization; medical, nursing, and pharmacy scholarships; health fairs, forums, and educational lectures; emergency medical service and telephone service; area health planning and implementation; and other activities. We may point also with pardonable pride to the twenty years of work and some 200 nursing scholarships supported by our esteemed co-workers of the Hampden District Medical Auxiliary.

I look forward to working as a member of the team in the ensuing year which promises to be a challenging one. I express personal gratitude for the fine spirit of cooperation I have received in setting up our committees for the year.

John W. Turner

John W. Turner, M.D.

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John E. Yelle	1972
David E. Booker	1973

Ernest A. Byron, Jr.

* * * * * *

SPRINGFIELD

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IN MEMORIAM
MACEO D. McGOODWIN, M.D.
1908 - 1970

Dr. Maceo D. McGoodwin of the Veterans Administration Hospital, Northampton, Mass., died at the Springfield Hospital Medical Center on March 29, 1970.

Born in Princeton, Kentucky, on June 15, 1908, Dr. McGoodwin graduated from West Virginia State College in 1933 and received his doctorate in medicine from Middlesex University School of Medicine in 1941. After serving an internship at the St. Agnes Hospital in Raleigh, N.C., and a residency at the Trinity Hospital in Detroit, Mich., he came to Springfield, where he engaged in the general practice of medicine for 19 years. In 1963, Dr. McGoodwin gave up private practice for a full-time position at the Veterans Administration Hospital in Northampton.

Dr. McGoodwin was a member of the American Academy of General Practice, the Mass. Medical Society, the HDMS, and the Springfield Academy of Medicine.

To his family, his friends, and associates deepest sympathy is hereby extended.

MARK YOUR CALENDAR NOW!

HDMS Meeting, September 22.

HDMS Executive Committee Meetings, June 16 and September 15.

HDMS Golf Day, Elmcrest Country Club, East Longmeadow, July 15.

MMS Annual Council Meeting, Boston, May 20.

MMS Annual Meeting, Boston, May 26-28.

American Diabetes Association, St. Louis, June 13-14.

AMA Annual Meeting, Chicago, June 21-25.

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ADVENTURE IN CRYSTAL GAZING

"Predicting? Wise men never try."
— Anon.

In this day of flux and change, there are very few things that can be predicted with any degree of certainty. One of these is that change will always be with us, just as it has in the past. The only difference is that as time goes on it may well be expected to accelerate faster than ever before. In support of this contention we have history on our side. One small example: whereas 3,000 years had to elapse between the harnessing of wind power and water power, only 40 years elapsed between the harnessing of oil energy on the one hand and atomic energy on the other.

Another plausible prediction is that in the months ahead we'll be hearing more and more about the enactment of some form of national health insurance in our land. The basis for this prophecy is to be found in the long list of health insurance plans now under consideration in Washington. The air in our capitol, in fact, is so surcharged with the topic that one observer was moved to quip: "It would seem that everybody here wants to get into the act."

HERE ARE SOME OF THE PLANS:

1. AMA Plan

The AMA's "medicredit" bill, estimated to cost about $10 billion, would leave Medicare intact, and would apply only to persons under 65 years of age. It would be financed by income tax credits for purchase of private health insurance, ranging from 100% credit for families with an income of under $5,000, to 25% credit for families with $10,000 or more income. AMA's President Dorman believes that it will take 5 to 10 years before this country is ready for any universal insurance plan.

This plan was introduced in Congress in December, 1969.

2. REUTHER Plan

This plan would cover almost everyone and would be financed by Social Security taxes and general federal revenues. Estimated annual cost: $40 billion.

Rates for medical services would be set locally within guidelines formulated by Health, Education & Welfare Dept. as well as outside experts.

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The role of insurance companies would possibly be as fiscal intermediaries.

Quality control would be based on "guidelines" from HEW.

3. AETNA Plan

This plan would cover poor and uninsurable persons. By an insurance company pool for federally-determined benefits. Catastrophic illness coverage for everyone for costs exceeding state-determined amounts. It will be financed by federal and state funds plus small payments from low-income patients for federally determined benefits.

4. JAVITS Plan

This plan would be an extension of Medicare to all under 65, in effect paying 80% of the average man's medical costs and 100% for those now under Medicaid. Costs would be covered by Social Security taxes and general federal revenues. It would provide Federal grants for construction of family-care clinics, expanded outpatient departments and other ambulatory care facilities.

Role of insurance companies: unchanged for uncovered 20% of average man's health costs.

5. GRIFFITHS Plan

This plan was introduced in February by Rep. Martha Griffiths of Michigan. It would be financed as follows: Employers would pay 3% of payroll, employees 1% and the Federal Government would match the employer's contribution. Estimated annual cost $33 billion. This plan has the support of The AFL-CIO, which plans to lobby for it strongly in Washington.

OTHER STRAWS IN THE WIND

In addition to the above fairly well defined programs there are indications that a number of other plans are potentially in the making. Here are some of these indications:

ITEM: Although President Nixon during his 1968 campaign expressed opposition to compulsory health insurance, his administration today sounds reconciled to the inevitability of such a plan.

ITEM: Former Secretary to HEW, Wilbur Cohen, is of the opinion that one or both political parties will include in their 1972 platforms a commitment to some form of national health insurance. His advice is often sought by many Washington solons.

ITEM: Dr. R. O. Egeberg, Assistant Secretary of HEW, believes that national health insurance is coming, but warns that it ". . . . probably would be six or seven years before you could feel that you were anywhere near ready to tackle this, without having a degree of chaos." His chief reason for the delay: professional man power shortage will become much more acute with the enactment of any type of universal health insurance.

ITEM: Our own Senator Ted Kennedy is in the midst of preparing a universal health insurance bill, which he is planning to make use of in his re-election campaign this year.

CONTROLS AND RESTRICTIONS

Aside from the method of financing, the AMA plan differs from all others in two main respects: (a) it is voluntary and (b) it is free of governmental in-

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trusions, controls and restrictions. It is these bureaucratic controls that are responsible for the erosions apparently inherent in all health programs enacted to date by the government. They all seem to be suffering inexorably from the law of diminishing returns. Thus, as time goes on the recipient gets less and less, and so does the vendor; paper work increases; subsidies to research, medical schools and hospital construction, gets smaller and smaller; and the price of the program gets costlier and costlier. The latest example is that Medicare's Part B premium, partially covering physicians' fees, will go up from $4 to $5.30 a month, beginning July 1, 1970.

The situation in Western Europe is apparently no better. Britain's National Health Service plan (which, incidentally, is used as a model by most of the proposed programs in this country), is now seriously considering the ultimate elimination of all forms of private practice. Notwithstanding earlier promises, government spokesmen are now threatening to eliminate all private practice beds in NHS hospitals. Another example is Sweden, where starting July 1, 1970, each patient will have to pay the government $1.50 to $2.00 each time he makes a routine visit to a doctor, hospital or clinic.

THE HAMPDEN QUESTIONNAIRE

In a questionnaire, earlier this year, Hampden District included two questions concerning the AMA Tax Credit Plan. Eighty respondents either fully or partially understood the plan, while almost twice as many (157, to be exact) disclaimed any knowledge of it. It is safe to assume that we would all show more interest in the AMA plan if we knew more about it as well as about all the other alternate plans. Once we have sufficiently familiarized ourselves with these plans, we would all do well to follow President Mozden's advice and make our beliefs known. This is wise counsel. Even greater wisdom is contained in the final sentence of his "Page" (*Hippocrat*, March, 1970), which reads: "Apathy can easily be assumed to be compliance and agreement with a proposal made by a few, and sometimes, made by but one."

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MEMBERSHIP QUESTIONNAIRE

(EDITOR'S NOTE: The following is a tabulation of the returns to a questionaire which Dr. Walter S. Mozden sent to some 500 HDMS members in November of 1969. At the end of each question's tabulation is Dr. Mozden's summary and interpretation thereof as reported by him at the Annual Meeting of HDMS on April 28, 1970).

1. POST-GRADUATE EDUCATION
   a. Do you feel this is advisable?
      Yes 142 No 10
   b. Do you feel this is necessary?
      Yes 121 No 26
   c. Would you prefer that post-graduate education be arranged by:
      1. Massachusetts Medical Society 30
      2. Hampden District Medical Society 19
      3. A local hospital 36
      4. Combination of above 74
   d. Would you attend such a post graduate course even though a moderate fee were required?
      Yes 115 No 19
   e. Would you prefer to arrange for such post-graduate on-going education on your own?
      Yes 101 No 37

Vast majority feel it is advisable; vast majority feel it is necessary; a varying opinion as to whether it should be arranged by the MMS, the HDMS, a local hospital or combination of these. The majority of physicians would be willing to pay a fee for this post-graduate education.

2. HEALTH INSURANCE
   a. Do you favor a national health insurance program?
      Yes 56 No 83
   b. Do you believe a compulsory health insurance program is necessary? Yes 58 No 78
   c. Do you believe a compulsory health program is inevitable?
      Yes 105 No 35
   d. Do you favor the AMA sponsored "tax credits" alternative to national health insurance?
      Yes 36 No 40
   e. Do you fully understand the AMA tax credits plan?
      Yes 28 No 102
   f. Do you partially undertsand it?
      Yes 52 No 55
   g. Do you believe it has any chance of being adopted?
      Yes 19 No 60

A slight majority would not prefer such a program, and feel that compulsory health insurance is not necessary; a vast majority (3 to 1) believe compulsory health insurance is inevitable.

Regarding the AMA sponsored "tax credits" alternative plan to national health insurance, a majority do not

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favor it, a vast majority (4 to 1) do not fully understand it, and a majority do not even partially understand it. A vast majority do not feel it has any chance of being adopted.

3. AUTOMATED LABORATORY

Do you favor a central automated laboratory of Hampden County run privately by local pathologists for profile chemistry?

Yes 81 No 48

The majority of physicians favor a central automated lab in Hampden County run privately by local pathologists for profile chemistry.

4. AMA DUES AND POLITICAL ACTIVITY

a. Do you believe the AMA dues are too high? Yes 84 No 22

b. Do you believe the AMA dues are low? Yes 7 No 72

c. Do you believe the AMA has become too political?

Yes 51 No 84

d. Not political enough?

Yes 48 No 40

The majority of physicians (4 to 1) feel that the AMA dues are too high, and yet a majority feel that the AMA should become more active politically.

5. FEDERATION OF PHYSICIANS

a. Do you favor such an organization? Yes 35 No 97

b. Do you believe the same aims could be accomplished via a committee within the Massachusetts Medical Society?

Yes 107 No 15

c. Do you believe the Massachusetts Federation of Physicians is similar in its aims to the American Association of Physicians and Surgeons? Yes 31 No 20

d. Do you personally favor a greater political activity by the Massachusetts Medical Society?

Yes 102 No 36

e. Do you favor less political activity by the Massachusetts Medical Society? Yes 18 No 88

The vast majority do not favor such an organization, the vast majority (7 to 1) believe the same aims could be accomplished via a committee within the MMS, and the vast majority believe that the MMS should take on a greater political activity.

6. FEE SCHEDULE

a. Do you believe a national or regional fee schedule is inevitable?

Yes 92 No 40

b. Do you favor a clear cut fee schedule with regional variations?

Yes 91 No 44

c. Do you favor a clear cut fee schedule with no regional variations? Yes 27 No 83

d. Do you oppose any and all clear cut fee schedules?

Yes 33 No 85

e. Do you favor a point value system as we have in our district?

Yes 89 No 32

f. Do you favor a point value system but with less variation, i.e. with more restriction on value per point? Yes 24 No 75

The majority believes that a national or regional fee schedule is inevitable, the majority favors fee schedule, and yet, the majority favors a relative value point system, rather than a fee schedule.

7. SALARIED PHYSICIANS

For Emergency Room Service, do you believe the following are ethically acceptable?

a. Private billing by the physicians as a group with the hospital guaranteeing a certain amount? Yes 113 No 22

b. Hospital does the billing and physician is paid a definite fixed value per hour? Yes 49 No 70

c. Hospital does the billing for the doctors and guarantees a minimal amount but also returns all the collected payments to the physician group? Yes 95 No 25

It is apparently becoming common practice in some hospitals in Massachusetts for a salaried physician to receive at least part of his salary through an arrangement whereby fees for physicians services are divided on a percentage basis between the salaried physician and the hospital.

a. Do you favor such a practice? Yes 25 No 106

b. Do you believe it to be ethical? Yes 44 No 83

c. Do you fell it may not be legal? Yes 63 No 46

The majority believes that (a) private billing by the physicians themselves with the hospital guaranteeing a certain amount, and (b) the hospital doing the active billing but returning all the collected payments to the physician group are ethically acceptable.

The majority do not believe that the practice whereby a hospital does the billing and pays the physician a prearranged fixed value per hour is ethically acceptable.

Regarding the increasing practice in hospitals whereby receipts for salaried physicians services are divided on a percentage basis between the hospital

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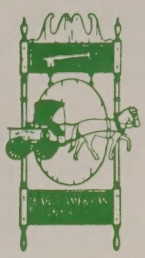

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and the physician, the vast majority do not favor such a practice, the majority do not believe it is ethical, and the majority believe it may not be legal.

8. MEDICAL SCHOOL

a. Would you prefer to have had the University of Massachusetts Medical School at Amherst?
Yes 121 No 11

b. At Worcester? Yes 1 No 100

c. Would you prefer no new medical school but rather, have the existing schools expanded and enlarged? Yes 69 No 64

9. PEER REVIEW

We will be hearing more and more about peer review, both in regard to quality of work and amount of fees and charges by individual physicians. Do you favor more individual peer review in regard to:

a. Quality of work in the hospitals?
Yes 104 No 46

b. Quality of work in the office?
Yes 63 No 69

c. Fees and charges by individual physicians? Yes 77 No 61

d. Would you favor our establishing a peer review committee?
Yes 79 No 57

The majority favor more individual peer review in quality of work in the hospitals, the majority do not favor more peer review in regard to office practice, the majority do favor peer review of individual fees and charges, and the majority definitely favor our establishing a peer review committee.

10. PUBLIC RELATIONS

Admittedly, the medical profession has been playing a larger and more active role in the public political arena. The majority of our physicians believes that we have not gained from this activity either in regard to our public image or economic position, and yet, the majority believes we should play an even greater role politically and the majority also believes the MMS should engage the services of a larger and more active public relations team. On a local level, the majority also favors one or more county societies engaging such a team for local effectiveness, and admits its willingness to support same financially.

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ALL-DAY SYMPOSIUM

CONTINUING PROBLEMS IN GASTROINTESTINAL DISEASE

8:30 *The Diagnostic Value of the History of Esophageal Disorders.* Philip Kramer, M.D.
The Surgical Treatment of Esophageal Motility Disturbances. F. H. Ellis, Jr., M.D.
New Concepts of the Physiology of Peptic Ulcer Disease. William Silen, M.D.
Peptic Ulcer Therapy: Medical Aspects. Jarrett H. Folley, M.D.
Peptic Ulcer Therapy: Surgical Aspects. Stanley O. Hoerr, M.D.
Clinical Applications of Bile Salt Metabolism. Donald Small, M.D.
Dilemnas in the Management of Gallstones. Frank Glenn, M.D.
Current Therapy of Pancreatitis. Frank P. Brooks, M.D.

12:00 SECTION LUNCHEONS: Allergy, Anesthesiology, Radiology, Internal Medicine, Physical Medicine.

2:00 *Modern Concespts of Viral Hepatitis.* Thomas C. Chalmers, M.D.
Management of the Patient in Coma. Charles Trey, M.D., and William V. Mc Dermott, Jr., M.D.
Newer Radiologic Techniques in the Diagnosis of Gastro-Intestinal Bleeding. Herbert L. Abrams, M.D.
Malabsorption Problems of the Small Intestine. Kurt J. Isselbacher, M.D.
New Concepts of Inflammatory Diseases of the Large and Small Bowel. Henry D. Janowitz, M.D.
Diverticulitis: Indications for Surgery. Grant V. Rodkey, M.D.

Wednesday, May 27

8:30 *Borderline Problems in Medical Ethics — 1970.* Panel.

11:00 The Shattuck Lecture — *The Physician and Organized Medicine.* C. Rollins Hanlon, M.D.

12:00 SECTION LUNCHEONS: Dermatology, Industrial Health, Obstetrics and Gynecology, Pediatrics, Physiology and Pathology, General Practice.

2:00 ANNUAL MEETING OF THE SOCIETY.

3:30 Annual Discourse — *Youth in Protest: Overtones for Medicine.* Dana Farnsworth, M.D.

6:00 Members and Guests Reception.

7:00 Annual Dinner. Speaker: Ralph Nader.

Thursday, May 28

8:30 *The Future of Delivery of Medical Care in Private Practice.* Panel.
Distribution of Manpower and The Distribution of Need. Olser L. Peterson, M.D.
What Can Medical Schools Do to Foster Community Practice? Sidney Lee, M.D.
Effect of National Insurance on the Economics of Medical Care. Samuel P. Martin, M.D.

12:00 SECTION LUNCHEONS: Opthalmology, Psychiatry and Neurology, Surgery, Orthopedic Surgery.

2:00 *Abortion — Promise or Peril. A Current Overview.* Panel.

PLANS FOR THE TEACHING OF COMMUNITY MEDICINE UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL

by

HUGH S. FULMER, M.D.
PROFESSOR AND CHAIRMAN DEPT. OF COMMUNITY MEDICINE
UNIVERSITY OF MASS. MEDICAL SCHOOL

INTRODUCTION

The first class of sixteen students enters the new medical school in September. Detailed planning for the curriculum is now in progress as key chairmen join the faculty. One of the cardinal features of the teaching program design will be an attempt to introduce methods of recently demonstrated merit to compliment those concepts of medical education which are time-tested and of undebated excellence. One area of medical education, often downtrodden, ignored, or given brief and inconsequential attention, has during the past decade taken on a new urgency and importance, in part reflective of and responsive to the age in which we live. This area, traditionally labeled public health or preventive medicine, has suffered badly in many schools because of insufficient recognition of its significance by administration and faculty, poor budgetary support, few and often part-time departmental faculty, unimaginative and inappropriate teaching programs, and inevitably failure to stimulate and interest medical students. But based on developments of the past decade, and particularly on intimate acquaintance with a formula that has been found to work, a teaching program in community medicine will be initiated here.

DEFINITION

Community medicine may be defined as the discipline concerned with the identification and solution of the health problems of communities or human population groups. Its basic sciences are epidemiology and biostatistics, though it draws liberally from the clinical, laboratory, and behavioral sciences. Preventive medicine, public health and social medicine are terms that, traditionally defined, are included in the scope of community medicine. As an undergraduate teaching endeavor, the community sciences may be viewed as the third side of a triad, the other two of which are the laboratory and the clinical sciences. Hence, it should not be regarded as a medical specialty in undergraduate teaching, but a domain to which all medical students should be adequately exposed. Each student will

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eventually become a physician for his community by nature of the professional responsibility he automatically assumes, no matter what specialty area — if any — he professes; the basic knowledge, skills and abilities that characterize community medicine are transmissible during the medical school years. That he has such a community obligation in no way implies less concern for sick individuals; indeed, it usually will serve their welfare more as the doctor brings to bear the community's resources in dealing with them.

If the community is viewed as consisting of a population, and its environment as everything "outside of the skins" of that population, then an ongoing interaction of population with environment produces the state of health of that community. In attempting to deal with its health status, consisting of a varying pattern of disease and disability, the community responds by producing a health services system, drawing from whatever sources, locally and elsewhere, composed of whatever variety of sub-systems, and meeting the particular needs of that community with varying degrees of effectiveness and efficiency. The study of the elements of this concept and their interaction is the task for the student of community medicine.

OBJECTIVES OF TEACHING PROGRAM

The objectives of the teaching program in community medicine include the acquisition of certain kinds of knowledge, skills and attitudes related to the basic components of the concept.

Knowledge would be obtained by the traditional methods, i.e., textbooks, journals, prepared material from multiple sources, lectures, seminars — the gamut of classroom teaching; but most of it would be acquired through actual living, observation and study in the community itself.

THE CLINICAL ANALOGY

The essence of the teaching of clinical medicine may be found at the bedside of the hospitalized patient, where the principles of diagnosis and treatment are carefully learned by each medical student through the painstaking application of the techniques of history taking, physical examination and appropriate laboratory testing followed by rational selection of individualized therapy. It is axiomatic that these principles can't be adequately taught in the classroom or absorbed from textbooks; they have to be learned from working with patients, and most effectively and efficiently, under careful faculty guidance.

Just so, the locus for the learning of community medicine is in the community, where the burden of illness with which each community suffers may be appreciated at first hand, and where the resources for dealing with these health problems may be carefully observed, described and understood. The teaching "ward", then, of a department of community medicine, becomes any community in a region, in this case anywhere within the Commonwealth.

The student learns that the health status of a community may be comprehended and diagnosed; he learns what may be necessary to adequately care for the health needs of the community. Being a future leader in matters pertaining to the health of the

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community, he needs to be educated in this "hospital without walls" as crucially as he needs to continue to learn the science and art of caring for sick people in the hospital. And, as on the ward he has careful guidance and supervision, so too in the community. Practicing physicians serve as "field faculty" and members of the Department of Community Medicine serve as active visiting teachers for the student. Unlike in the old-time preceptorship programs, however, the student does not merely participate in the physician's practice; he attempts to observe, describe, analyze, and interpret the totality of health needs and resources in the community. Using a scientific approach, he obtains particular knowledge concerning the population and its environment in order that he may try to comprehend the community's health status and its health services system.

IMPLICATIONS

The major community clerkship, problably of six weeks duration, would take place in the senior year. However, it is important that the student be sensitized to the world of medicine early. Therefore tentative plans include assignment of *first* year students to various communities, including Springfield, in order to stimulate them to thing about community medical problems throughout the undergraduate years.

Study of the "health services system", one of the four components of community medicine, embodies such matters as the objectives, functions, administration, staffing, organization, and budgeting of various institutions involved in the delivery of medical care including hospitals, extended care facilities, nursing homes, medical practices, home care programs, health departments, dental practices, pharmacies, and voluntary health agencies.

These topics can readily be studied by the first year student. Their review does not require the degree of knowledge that a four year student would possess as a near graduate. During such a first year community clerkship, he would study these areas as an observer. In this time of alleged crisis in medical care delivery systems, it is important that he seek to understand their functioning and how they meet the needs of the people right from the beginning of his medical education. Whether the complex of medical care resources in the community can incorporate the characteristics of comprehensiveness, continuity, competence, compassion, and family orientation may serve as one guideline; how the medical profession can grapple successfully with the increasing complexities in living up to its trust will be a challenge that each student will have to confront; through early exposure, he will be inspired to think seriously about his role as a professional in exerting health leadership in the future.

During the first three years the student gradually learns how to perform a history and physical examination of an idividual patient which has usually become by his senior year an acceptably skilled procedure. Already somewhat familiar with the approach to the study of the community through his first year exposure, the student as a senior will gather information on the history of the health status of the community, examine its present status by studying individual patients (which he works up), families (which he works

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up), health facilities, and community health services, public and private. Based on this "history and physical examination" of the community, the student learns to formulate a clinical impression and develop a realistic plan for improvement of the health status. The conclusions reached, through based on incomplete and fragmented data, and interpreted by an unsophisticated observer, sometimes have potential for application in that community, and though the study may be viewed merely as an academic exercise, it can also be a stimulus for serious thought and action.

It is worthy of emphasis, however, that the average student — though more often "activist" than even a couple of years ago — undergoes the humbling experience of recognizing that action has to be based on knowledge and sound judgment if it is to be intelligent. Thus he can't perforce be an "action agent" as a student in this context, if this indeed is what a situation might seem to demand; the closest he would come would be in the nature of a catalyst.

The clinical study of patients and families in the community emphasizes the exercise of certain skills which should be used in hospital work-ups, but which have a tendency to atrophy from disuse in that setting. In the community, of course, there must also be a sound clinical assessment, but specific skills used to obtain and apply epidemiologic information are stressed by the nature of the locale. Thus, clinical epidemiology, or the use of epidemiology in individual patient care, is reinforced. The view of disease in the patient as being a reflection of his geographical, occupational, familial and cultural environment, as well as his heritage, comes alive.

It will be necessary at times to work with a variety of community leaders, community organizations, and their members. The student begins to appreciate what is involved in such activity; it is an aspect of the art that would ultimately only be acquired through experience, but which at the outset requires skills in human relationships.

Many students enter medical school with the desire to serve the people as practicing physicians. Sometimes this noble aim has been eroded by the time they graduate. In part the educational atmosphere within the University Medical Center is responsible. The practicing physician in the community is not on center stage; he has little opportunity to demonstrate how the practice of medicine is conducted in serving the needs of the public; his key role and significance tend to remain peripheral in location and in thought. By living and working in the community, observing how its health needs are handled, the student's interest in dealing with the health problems of the people in their natural setting is rekindled; whether he ultimately chooses a career in general or specialty practice, research, academic medicine, public health or whatever, his awareness and concern for what transpires in the community is bound to be enhanced. Indeed the experience has been that students re-examine critically and sometimes change career choice based on what is a more balanced knowledge of the real world.

(To be concluded next month)

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